MH 718
Revised 4/19/16

SERVICE REQUEST LOG

Provider Number (5 digit program code): _____

I. Request Information

Date of Request: _____ Recording Staff: _____

Time of Request: _____ Request Type: ☐ Call ☐ Walk-In ☐ Other ☐ SRTS

Reason for Request: _____ SRTS Reference Number: _____

II. Requester/Referring Party

Last Name: _____ First Name: _____ Contact Number: _____

Referring Party Role:
☐ Self ☐ Collateral/Family Member ☐ ACCESS ☐ Other
☐ DCFS ☐ Health Provider ☐ Inpatient Facility ☐ School
☐ Probation/Law Enforcement ☐ APS ☐ Mental Health Provider ☐ DPSS

Referring Facility/Site/School: _____ Type of Role: _____

Is the client/potential client aware of the referral? ☐ Yes ☐ No

III. Client/Potential Client Information

Existing Client: ☐ Yes ☐ No Client ID: _____

Potential Client Last Name: _____ Potential Client First Name: _____

Potential Client Contact Number: _____ Potential Client DOB: _____

Insurance Status: ☐ Indigent ☐ Medi-Cal ☐ Medicare ☐ Medi-Medi ☐ Private Insurance ☐ Unknown

Preferred Language: _____

If Minor's Legal Guardian is not the referring party: Legal Guardian Name: _____
Contact Number: _____ Preferred Language: _____

Release From: ☐ Inpatient ☐ Juvenile Hall ☐ Jail ☐ N/A If release from inpatient facility, name of facility: _____

Currently Receiving Mental Health Services: ☐ Yes ☐ No ☐ Undetermined If yes, where/from whom? _____

Emergent Medication Needs? ☐ Yes ☐ No ☐ Undetermined If undetermined, reason? _____

If emergent, was the medication appointment scheduled for the same day as the assessment appointment entered below: ☐ Yes ☐ No

If no, justification: _____

Disposition
☐ Crisis Referral (this site, 911, FRO) ☐ Assessment Appointment Given This Site ☐ Referred to System Navigation
☐ Referred back to Private Insurance ☐ Referred to Another Mental Health Agency ☐ Referred to Other Type Agency
☐ Other ☐ Individual/Collateral Declined Services ☐ Unable to Contact Individual/Collateral
☐ Already Receiving Appropriate MH Services

If appointment given: Appointment Practitioner: _____ Appointment Program: _____
Appointment Date: _____ Appointment Time: _____
Was an earlier appointment offered: ☐ Yes ☐ No If yes, date of first offered appointment: _____

Disposition Details:

Comments, Cultural Considerations and/or Special Needs:

IV. ACCESS STAFF ONLY

ACCESS Appointment Line: ☐ Yes ☐ No Source: ☐ Managed Care Referral ☐ DHS eConsult Urgent/Routine: ☐ Urgent ☐ Routine

Referring Health Plan:
☐ LA Care ☐ Health Net ☐ Beacon Behavioral Health ☐ MHN Behavioral Health ☐ Kaiser
☐ Anthem ☐ Care 1st ☐ Molina ☐ Other ☐ Indigent

Staff Signature*	Date	Co-Signature*	Date

SERVICE REQUEST LOG (SRL)